Advicor, Altoprev, Caduet, Lescol, Lescol XL, Livalo, Simcor

Antilipidemic Drugs I – US Family Health Plan Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program (USFHP).

MAIL ORDER	**If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here** ☐	**RETAIL**	**If the prescription is to be filled at a retail pharmacy, check here** ☐
	• The completed form and the prescription may be **faxed** to **1-617-562-5296** OR • The patient may attach the completed form to the prescription and **mail** it to: **Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135**		• The provider may **call**: **1-877-880-7007** OR • The completed form may be **faxed** to **1-617-562-5296**

Prior authorization criteria and a copy of this form are available at: http://www.usfamilyhealth.org/f-downloadable_forms.html This prior authorization has no expiration date.

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name: _____ Physician Name:_____
Address: _____ Address: _____
_____ _____
Sponsor ID: _____ Phone #: _____
Date of Birth: Secure Fax:

Circle medication requested: Advicor Altoprev Caduet Lescol Lescol XL Livalo Simcor

Step 2 Please complete the clinical assessment:

1. Has the patient had a trial of lovastatin (Mevacor), pravastatin (Pravachol), simvastatin (Zocor), or Lipitor (atorvastatin)?	☐ Yes Please sign and date below	☐ No Proceed to Question 2
2. Is the request for Lescol, Lescol XL, or Livalo?	☐ Yes Proceed to Question 3	☐ No Proceed to Question **4**
3. Is the patient taking a concurrent drug that is metabolized by the CYP3A4 system?	☐ Yes Please sign and date below	☐ No Proceed to Question 4
4. Is the request for Advicor or Simcor?	☐ Yes Proceed to Question 5	☐ No Coverage not approved
5. Does the patient require a drug that decreases LDL and increases HDL?	☐ Yes Proceed to Question 6	☐ No Coverage not approved
6. Is the patient able to take niacin and a statin as two separate tablets?	☐ Yes Coverage not approved	☐ No Please sign and date below

Step 3 **I certify the above is correct and accurate to the best of my knowledge.**
Please sign and date

_____ _____
Prescriber Signature Date